Choices for Care - Moderate Needs Group
Service Authorization

Individual Name: _____ **Phone#:** _____
Last, First

Birth Date: _____ **SS #:**_____ ☐**Male** ☐**Female**

Address: _____

_____ **ICD-9 Code:** _____

Town of Residence if other than mailing address:
_____**Error! MergeField was not found in header record of data source.**

The following services are authorized:

☒**Case Management** – Limited to up to 12 hrs/yr @ $67.44/hr ($67.44 ave./mo)
Agency/Provider Name: _____

☐**Homemaker** – Limited to up to 6 hrs/wk @ $18.68/hr ($482 ave/mo)
Agency/Provider Name: _____

☐**Adult Day** – Limited to up to 30 hrs/wk @ $15/hr ($1,935 ave/mo)
Agency/Provider Name: _____

NOTE: Actual service hours will be determined by service provider's assessment and based on need.

Case Manager's Name: _____

Department of Disabilities, Aging and Independent Living Authorization/Official Use Only

Services are authorized effective Start Date: _____ through End Date: _____

_____ _____
DAIL Authorized Signature *DATE*